Health & Social Care Navigators in General Practice:

Towards an Implementation Framework for Social Prescribing in Primary Care

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Background to the review

- Increasing or persistent fragmentation of health and social care services
- Patients in general practice presenting with (age and lifestyle related) multimorbidity and complex needs
- Access to general practice / general practice workloads under stress
- Growth of care navigator roles in general practice to support care management, care coordination and social prescribing
- IFIC Australia partners (especially PHN representatives) commission review due to lack of understanding on how these roles can best be embedded in general practice and what evidence there is for improving value in health and care services

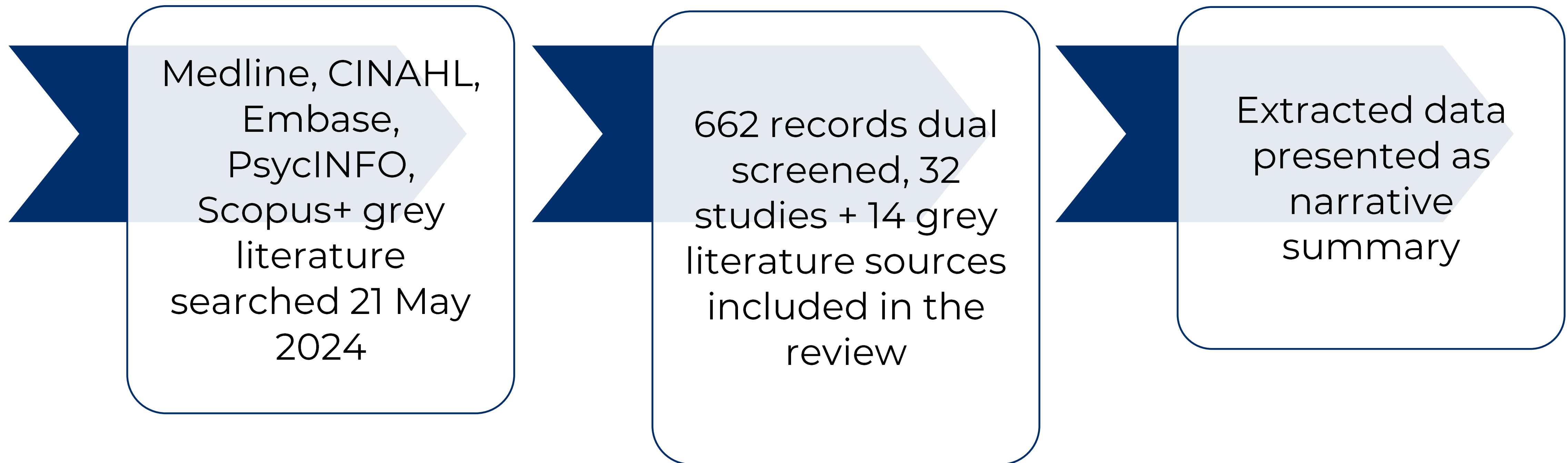
Aim of the review

Care navigation in general practice aims to connect patients to health, social and community services. The initiative seeks to support patients presenting with complex needs to gain access to ongoing care and support.

This scoping review sought to answer the following questions:

1. What tasks and responsibilities do care navigators in general practice undertake?
2. What is the experience of the role from the point of view of: patients; other general practice staff members, including GPs; and the navigators themselves?
3. **What is the impact of care navigators in general practice?**
4. **What are the key factors to consider when introducing care navigators into general practice?**

Methods



Results: overview

21 United Kingdom
4 Canada
3 United States
3 Australia
1 Portugal

19 qualitative methods
5 mixed methods
8 quantitative methods

4 studies examined general practice-based care navigation services during COVID-19

Results:
What is the impact of care navigation in general practice?

- Fewer than a third of included studies examined the impact of CNs in general practice (9/32)
- Improved outcomes for patients were reported in over half these studies (5/9)
- Several studies found no change in patient outcomes and/or low levels of engagement with CNs
- There is some evidence that the costs of care navigation in general practice can be recovered and provide a return on investment

Key messages _ impact

1. Significant investment made introducing care navigators in general practice, specifically as social prescribers, but **limited evidence** on their effectiveness.
2. Care navigation shown to contribute to **better health and wellbeing outcomes for targeted individuals**, but **less evidence for the effectiveness on system–level outcomes** such as reducing hospitalisations and health resource utilisation.
3. The **lack of evidence may be discouraging funding bodies to invest**. Key professionals, like **GPs, often hesitant to support care navigation services** without seeing the benefits to their practice and their patients.
4. New approaches to **evaluation should combine process with impact evaluations** to provide better evidence about how well care navigator programs are operating as well as their impact on people's care.

Results:

What are the key factors to consider when introducing care navigators into general practice?

Mapping the evidence: towards an implementation framework

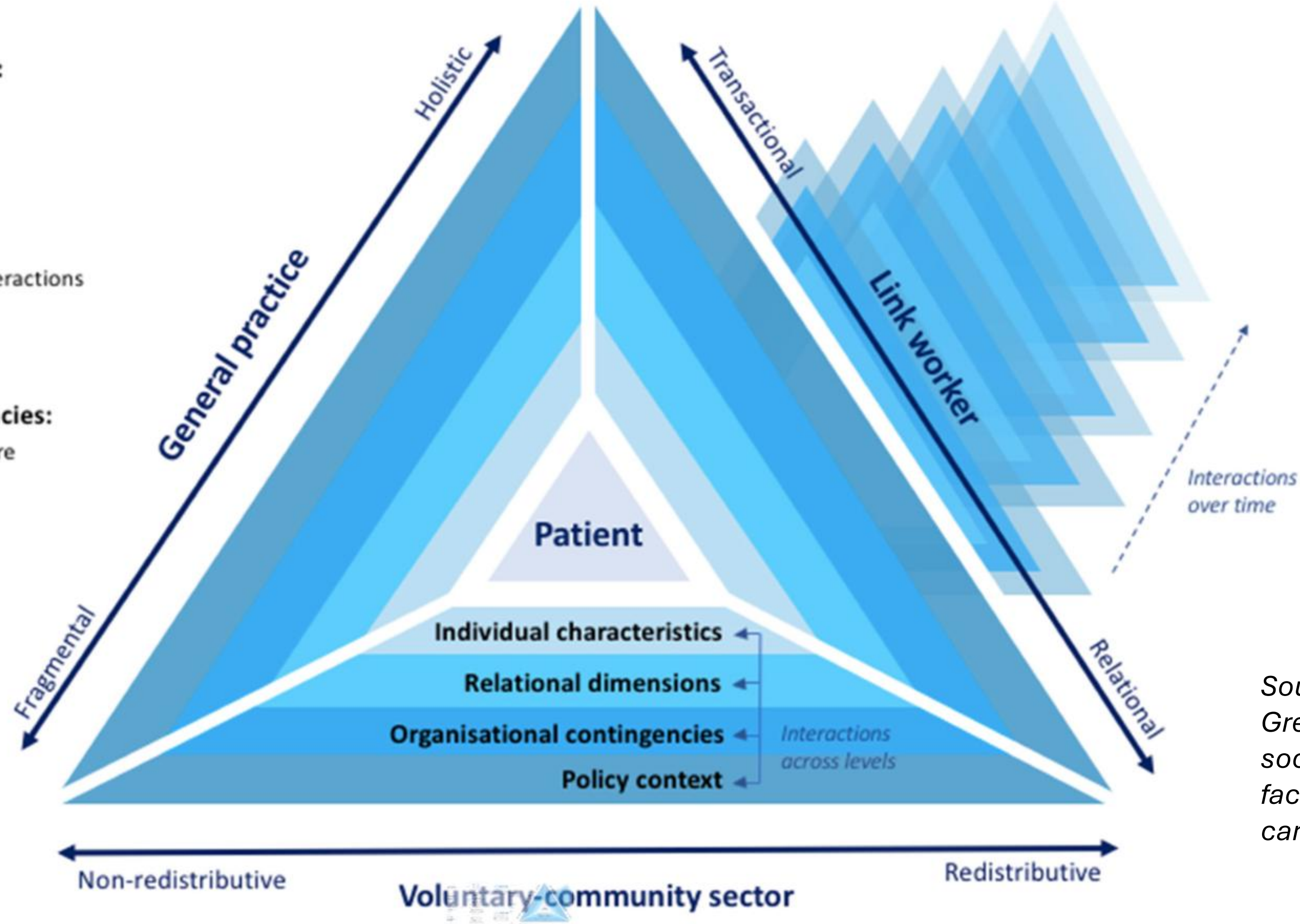
The data from the primary studies extracted information on issues affecting the implementation of care navigation services. These issues were then presented as a series of positive statements, each describing a component which should be considered before implementation.

These statements were the mapped to a framework developed from the findings of a realist review by Calderon-Larranaga* and colleagues for evaluating social prescribing in primary care _ a CMO framework (context_mechanism_outcome). This resulted in meaningful groupings of causal elements across four inter-dependent contexts (individual, interpersonal, organisational, policy).

Within each context, our research identified three to eight mechanisms. In theory, the presence or absence of each mechanism affects whether outcomes might be considered 'best practice' (i.e. holistic, relational, redistributive) or 'worst practice' (i.e. fragmented, transactional, non-redistributive).

** Calderon-Larranaga S, Milner Y, Clinch M, Greenhalgh T, Finer S. Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review. BJGP open. 2021;5(3).*

A framework to facilitate the implementation and evaluation of social prescribing in primary care



Source: Calderon-Larranaga S, Milner Y, Clinch M, Greenhalgh T, Finer S. Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review. BJGP open. 2021;5(3).

Individual Characteristics

Context	Mechanism	Consideration
Individual characteristics	Buy-in	Referrals to a CN are a joint GP (or other referrer)-patient decision to ensure the patient is ready for change (13).
		Information is provided to patients about the new CN role, preferably by their GP (20-22).
		Strategies are in place to deal with resistance from patients at being 'signposted' away from the GP to other health professionals or social services (20).
		General practice staff are open and receptive to the care navigation service, and display a holistic, patient-centred attitude to care (19, 21, 23, 28, 30-32).
	Vocation	CNs can adapt, be flexible and creative and have good problem-solving skills (23, 25).
		CNs can prioritise workload and customise care navigation based on the intensity/complexity of patient needs (15).
		CNs possess the following personal qualities: flexibility, friendliness, resourcefulness, patience, empathy, trustworthiness, reliability and discreetness (17, 26).
		CNs can establish a positive relationship with patients, at the same time as setting and maintaining professional boundaries (24, 26).
		CNs have clear pathways for career progression (24).
	Knowledge	CNs have previous experience in health or social care and/or mental health (17, 23, 24).
		CNs know the range of VCSE services and activities available in their area; mapping of existing local assets has been undertaken before implementation of the CN role (18, 24, 29, 31).

Interpersonal Relationships

Interpersonal relations	Trust	Relationships with existing, similar services are based on clear communication and cooperation to avoid confusion and professional tensions; collaboration is prioritised (20, 31).
		A personalised action plan is developed with patients and available to all practice staff and CNs (19).
	Bidirectional, informed interaction	CNs have an appropriate workload to ensure minimal waiting times and ability to follow up with patients as needed. There is recognition that some patients need intensive support which will require higher levels of CN engagement (19, 21, 24).
		All relevant stakeholders acknowledge the inherent tensions between intensive patient support and patient empowerment, i.e. ‘handholding’ versus ‘light touch’ approaches (21, 22).
	Support	Buy-in from the local community is in place, particularly in relation to reducing social isolation (25).
		Buy-in from the VCSE sector is in place (21, 33).
	Transparency	There is effective, regular communication between CNs and other practice staff (19).
		Care navigation services are not already being provided by other health professionals in a multidisciplinary practice (13).
		The CN role is clearly defined with agreed scope and boundaries; the CN is not reassigned to other duties at the expense of their core responsibilities (15, 17, 28-30).
	Convenience	CNs function as a single or first point of contact for patients; patients can contact their CN directly (28, 40).
		CNs are physically based in general practices (rather than remotely in offices or working from home) to enhance visibility to patients and practice staff; CNs can do home visits when required (13, 31, 38, 39).

Organisational Contingencies

Organisational contingencies	Predisposed practice culture	The practice is able to manage other innovations at the same time as a care navigation program (30).
	Leadership	There is at least one GP (or other key member of staff) champion of care navigation in the practice; there is a good level of GP buy-in (18, 23, 28, 30).
	Training opportunities	CNs have appropriate training in recognising and responding to people with mental health issues, including mental health first aid and suicide awareness (23, 24, 37, 39).
		CNs have appropriate training in relevant areas including domestic violence, housing, benefits, immigration and addiction (24, 39).
		CNs have appropriate training in competencies such as inter-professional communication, managing multimorbidity and complexity (15, 24, 35).
		Training is consistent for all CNs to ensure consistency of service (20).
		Pre- and in-service training is available to CNs (31, 37).
		All referring professionals have been trained to ensure appropriate referrals and suitability of patients for referrals (23-25, 28, 37-39).
	Supervision	CNs have access to coordinated, comprehensive support including clinical supervision, peer support, counselling and/or pastoral support (23, 25, 31, 36, 37, 39).
		Orientation programs for new CNs and clarity around the scope and expectations of the role are in place to minimise and manage CN staff turnover and prepare CNs for success (Chng, 2021; Morris, 2022; Pescheny, 2021).
	Information governance	CNs have read and write access to patient electronic medical records (17, 18, 31).
	Continuity of care	If mobile technology is used to facilitate communication between patients and CNs, it is easy to use and acceptable to patients (14, 35, 36).
		Appropriate targeting of patients most likely to benefit from care navigation is in place, for example through program intake screening (15).
	Resource adequacy	A phased program rollout allows for gradual change management and development of exemplar sites (31).
	Accessibility	Suitable, well-funded VCSE services and activities are available (local to the area, with capacity to take on participants) and accessible (low cost or free, near public transport) for CNs to refer patients to (17, 19-21, 23, 24, 31, 33).

Policy Context

Policy context	Bottom-up	Program processes are flexible to allow responses to change in population and practice needs (17).
	Policy coherence	The care navigation model of care and underpinning program logic are co-created with all relevant stakeholders (15).
		All relevant stakeholders share a clearly articulated vision, purpose and long-term objectives for the care navigation service (31).
		All relevant stakeholders acknowledge the inherent tensions between how the CN role is perceived and operationalised, e.g. patient-centred care, outcomes-based care, target (KPI)-based care (32).
		All relevant stakeholders have realistic expectations of what the CN role can achieve at the level of individual patients. For example, complex health and social care needs may not ever be 'solved' but can be improved (36, 39, 41, 42).
		All relevant stakeholders have realistic expectations of what the CN role can achieve at the system level. For example, resources may need to be shifted from health to social care so cost savings may not be achieved (41).
		All relevant stakeholders have realistic expectations of how CNs practice within program constraints. For example, the duration and number of appointments provided to each patient may be limited (37, 41).
		All relevant stakeholders have realistic expectations of the time needed to fully implement a GP-based CN program and allow effects of the program to be evaluated (30, 31, 39, 43).
		Collaborative governance is underpinned by formal inter-organisational agreements (12).
	Stable funding	Appropriate and ongoing funding is in place for care navigation programs and employment of CNs (17, 18, 25, 31).
		Flexible funding models allow for program funding from more than one source (12).
		The cost of care navigation services is covered by medical insurance or government funding in the same way as other health services (28).
	Suitable monitoring	CN core competencies are identified and formally recognised (15).
		Quality standards or benchmarks against which CN programs can be evaluated are in place (15, 22).
		Mechanisms for ongoing feedback and formal evaluation are in place; there are opportunities to make changes to the role or service in response to findings (31).
		Structural pressures from funding bodies (for example completion of output measures such as referrals, assessments) do not detract from quality care delivery towards activity measures (21, 24).
		Clear governance processes are in place to support collaboration across sectors (15).

Key messages _ implementation

- Key issues to consider for the 'successful' introduction of care navigators into general practice fall in four dimensions: individual, inter-personal, organisational and political
- The evidence on care navigation implementation supports the coherence of an evidence-based framework that could be used to guide implementation, with narrative 'measures' that identify and assess its practical components
- The development of such an implementation framework should be progressed (for example, using the Delphi method) and used/tested as part of future process evaluations
  - for example, to assess whether care navigation services in general practice are operating at their maximum implementation maturity and/or to understand if evidence-informed implementation practices lead to more value-based care

Thank You!

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